



INVITED COMMENTARY

Comments regarding 'Implications of Attendance Patterns in Northern Ireland for Abdominal Aortic Aneurysm Screening'

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The paper by Badger et al.¹ highlights some of the issues which surround screening in abdominal aortic aneurysms (AAAs). They are to be congratulated for their honesty in producing a paper based on a local screening program when the UK National screening program has already started, with considerable success, in several areas.

The authors have highlighted several of the difficulties facing those of us who run AAA screening programs. The most important one is probably the need to recruit most of the screening population in order to remain clinically effective. The authors argue that such a program would remain cost effective even if only 44.5% of individuals attended. This may be seen as dubious, but as most of the therapeutic cost lies in the management of the few AAAs discovered, it may be more understandable. What is less clear is the possible effect of intervening with endovascular aneurysm repair (EVAR) which probably doubles the overall cost of any intervention. This issue is even more pertinent as the AAA initially found in the UK program will be in 65 year old men who presumably will then need long term follow up following EVAR. Coupled with evidence that screen detected AAAs in young patients may only have an operative mortality after open repair of about 2.5%² then the jury must certainly be

considered to be still out as far as EVAR is concerned in this context.

The authors suggest that the main reason for non-attendance might be because of the deprived nature of the population. However, in Hull and East Yorkshire (which is by any standards an extremely deprived area within the UK) we have a "non-attendance" rate of only 15% with a further 15% cancelling because of personal problems to be later re-booked. This suggests that it is more likely to be the local organisation and structure of the screening program that is critical to maximising attendance.

Perhaps the single most important individual factor is near patient testing. Despite the suggestion of the authors to involve GPs, success has been attained without the involvement of local GPs. After all, these are essentially normal people who do not want to be inconvenienced and they do not need much excuse to justify avoiding attending a clinic. In this regard, the NHS screening program is to be congratulated, as it ensures that everything possible is in place to maximise attendance.³

The authors are correct to suggest that the use of a prevalence based on the 65–75 year old age group is likely to predict a falsely high number of AAAs. The initial year of the UK national screening program has only looked at 65 year old men. As few men die at 65 from ruptured AAAs, this should not be surprising! However, with the passage of years and long term follow up, the program will almost certainly find AAAs increasing in size until intervention is warranted.

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A more worrying issue here is the aorta which measures 2.5–3.0 cm. The UK AAA screening program does not currently mandate these patients to be followed up. Many involved with AAA screening will testify that these patients do in fact show aneurysm tendencies and certainly we have found that at least 50% will have a significant small AAA at 4 years (3.0–4.5) after initial screening which must surely dictate a change of policy in the UK screening program. As the rate of growth is related to AAA size,⁴ a follow-up screen at 4 or 5 years must surely be justified. After all, the “patient” will only be 70 years old at that point. Perhaps it is these “missed” subjects, who are indeed at risk of AAA formation, that might partly explain the current relatively low prevalence of AAAs in the UK study?

References

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